General Assembly

Raised Bill No. 252

February Session, 2010

LCO No. **1521**

01521_____INS

Referred to Committee on Insurance and Real Estate

Introduced by:
(INS)

AN ACT CONCERNING MEDICAL MALPRACTICE DATA REPORTING.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-395 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2010*):

(a) As used in this section:

(1) "Claim" means a **[**request for indemnification filed by a medical professional or hospital pursuant to a professional liability policy for a loss for which a reserve amount has been established by an insurer**]** demand for monetary compensation for injury or death caused by medical malpractice or a voluntary indemnity payment for injury or death caused by medical malpractice;

(2) "Claimant" means a person, including a decedent's estate, who is seeking or has sought monetary compensation for injury or death caused by medical malpractice;

[(2)**]** (3) "Closed claim" means a claim that has been settled **[**,**]** or otherwise disposed of **[**, where the insurer has made all indemnity and

expense payments on the claim**]** by the insuring entity, self-insurer or health care provider, where all indemnity and expense payments have been made. A claim may be closed with or without an indemnity payment to a claimant;

[(3) "Insurer" means an insurer that insures a medical professional or hospital against professional liability. "Insurer" includes, but is not limited to, a captive insurer or a self-insured person; and

(4) "Medical professional" has the same meaning as provided in section 38a-976.**]**

(4) "Commissioner" means the Insurance Commissioner;

(5) "Economic damages" means objectively verifiable monetary losses, including, but not limited to, medical expenses, loss of earnings, loss of use of property, burial costs, cost of replacement or repair, cost of obtaining substitute domestic services and loss of business or employment opportunities;

(6) "Health care provider" or "provider" means (A) a person licensed to provide health care services under chapters 368v, 370 to 372, inclusive, 375, 376, 377 to 379, inclusive, 380 and 381, or (B) an employee or agent of such provider acting in the scope of such employee's or agent's employment, or if such employee or agent is deceased, such employee's or agent's estate or personal representative;

(7) "Insuring entity" means (A) an authorized insurer, (B) a captive insurer, (C) a risk retention group, or (D) an unauthorized insurer that provides surplus lines coverage;

(8) "Medical malpractice" means an actual or alleged negligent act, error or omission in providing health care services;

(9) "Noneconomic damages" means subjective, nonmonetary losses, including, but not limited to, pain and suffering, mental anguish, disability or disfigurement incurred by the injured party, emotional

distress, loss of society and companionship, loss of consortium, inconvenience, humiliation and injury to reputation and destruction of the parent-child relationship;

(10) "Person" means an individual, a corporation, a partnership, a limited liability company, an association, a joint stock company, a business trust, an unincorporated organization or other legal entity; and

(11) "Self-insurer" means any health care provider or other entity or individual that assumes operational or financial risks for health care providers' liability claims.

(b) **[**On and after January 1, 2006, each insurer**]** Each insuring entity or self-insurer that provides professional liability insurance to any health care provider in this state shall provide to the Insurance Commissioner a closed claim report, on such form as the commissioner prescribes, in accordance with this section. The requirements of this section shall apply to all professional liability claims of health care providers in this state, regardless of whether or how such claims are covered by professional liability insurance. The **[**insurer**]** insuring entity or self-insurer shall submit the report not later than ten days after the last day of the calendar quarter in which a claim is closed. **[**The report shall only include information about claims settled under the laws of this state.**]**

(c) (1) A closed claim that is covered under a primary policy and one or more excess policies shall be reported only by the insuring entity that issued the primary policy. Such insuring entity shall report the total amount paid, if any, with respect to such closed claim, including any amount paid under an excess policy, any amount paid by the provider and any amount paid by any other entity or person on behalf of the provider.

(2) If a claim is not covered by an insuring entity or self-insurer, the provider named in such claim shall report the claim to the

commissioner after a final claim disposition has occurred by a court proceeding or settlement by the parties. A claim that is not covered by an insuring entity or self-insurer includes, but is not limited to, situations in which: (A) The provider did not purchase professional liability insurance or maintained a self-insured retention that was larger than the final judgment or settlement; (B) the claim was denied by an insuring entity or self-insurer because such claim was not within the scope of the coverage agreement; or (C) the annual aggregate coverage limit was exhausted by other claims payments.

(3) (A) If a claim is covered by an insuring entity or self-insurer and such insuring entity or self-insurer fails to report such claim to the commissioner, the provider named in such claim shall report the claim to the commissioner after a final claim disposition has occurred by a court proceeding or settlement by the parties.

(B) If a provider is insured by (i) a risk retention group, (ii) an unauthorized insurer, or (iii) a captive insurer, and such risk retention group, unauthorized insurer or captive insurer refuses to report closed claims to the commissioner on the basis of federal or other jurisdictional preemption or exemption, the provider shall report all data required by this section on behalf of such risk retention group, unauthorized insurer or captive insurer.

(4) The commissioner shall establish procedures by which (A) the Insurance Department shall determine when an insuring entity or self-insurer has failed to report a claim as required by this section, and (B) a facility or provider shall be notified when such provider is obligated to report closed claim data pursuant to this subsection.

(5) Any insuring entity or self-insurer doing business in this state that fails to file any report required under this section shall pay a late filing fee of one hundred dollars per day for each day from the due date of such report to the date of filing by such insuring entity or self-insurer or by a provider pursuant to subdivision (3) of this subsection.

[(c)**]** (d) The closed claim report shall include:

(1) Details about the insured and **[**insurer**]** insuring entity, including: (A) The name of the **[**insurer**]** insuring entity; (B) the professional liability insurance policy limits and whether the policy was an occurrence policy or was issued on a claims-made basis; (C) the name, address, health care provider professional license number and specialty coverage of the insured; and (D) the insured's policy number and a unique claim number.

(2) Details about the injury or loss, including: (A) The date of the injury or loss that was the basis of the claim; (B) the date the injury or loss was reported to the **[**insurer**]** insuring entity; (C) the name of the institution or location at which the injury or loss occurred; (D) the type of injury or loss, including a severity of injury rating that corresponds with the severity of injury scale that the **[**Insurance Commissioner**]** commissioner shall establish based on the severity of injury scale developed by the National Association of Insurance Commissioners; and (E) the name, age and gender of any injured person covered by the claim. Any individually identifiable health information, as defined in 45 CFR 160.103, as amended from time to time, **[**amended,**]** submitted pursuant to this subdivision shall be confidential. **[**The reporting of the information is required by law.**]** If necessary to comply with federal privacy laws, including the Health Insurance Portability and Accountability Act of 1996, **[**(P.L. 104-191) (HIPAA)**]** P.L. 104-191, as amended from time to time, **[**amended,**]** the insured shall arrange with the **[**insurer**]** insuring entity to release the required information.

(3) Details about the claims process, including: (A) Whether a lawsuit was filed and, if so, in which court; (B) the outcome of such lawsuit; (C) the number of other defendants, if any; (D) the stage in the process when the claim was closed; (E) the dates of the trial, if any; (F) the date of the judgment or settlement, if any; (G) whether an appeal was filed and, if so, the date filed; (H) the resolution of any appeal and the date such appeal was decided; (I) the date the claim was closed; (J)

the initial indemnity and expense reserve for the claim; and (K) the final indemnity and expense reserve for the claim.

(4) Details about the amount paid on the claim, including: (A) The total amount of the initial judgment rendered by a jury or awarded by the court; (B) the total amount of the settlement if there was no judgment rendered or awarded; (C) the total amount of the settlement if the claim was settled after judgment was rendered or awarded; (D) the amount of economic damages **[**, as defined in section 52-572h,**]** or the **[**insurer's**]** insuring entity's estimate of the amount in the event of a settlement; (E) the amount of noneconomic damages **[**, as defined in section 52-572h,**]** or the **[**insurer's**]** insuring entity's estimate of the amount in the event of a settlement; (F) the amount of any interest awarded due to the failure to accept an offer of judgment or compromise; (G) the amount of any remittitur or additur; (H) the amount of final judgment after remittitur or additur; (I) the amount of punitive damages, if applicable; (J) the amount paid by the **[**insurer**]** insuring entity; **[**(J)**]** (K) the amount paid by the defendant due to a deductible or a judgment or settlement in excess of policy limits; **[**(K)**]** (L) the amount paid by other **[**insurers**]** insuring entities; **[**(L)**]** (M) the amount paid by other defendants; **[**(M)**]** (N) whether a structured settlement was used; **[**(N)**]** (O) the expense assigned to and recorded with the claim, including, but not limited to, defense and investigation costs, but not including the actual claim payment; and **[**(O)**]** (P) any other information the commissioner determines to be necessary to regulate the professional liability insurance industry with respect to **[**medical professionals or hospitals**]** health care providers, ensure the industry's solvency and ensure that such liability insurance is available and affordable.

[(d)**]** (e) (1) The commissioner shall establish an electronic database composed of closed claim reports filed pursuant to this section.

(2) The commissioner shall compile the data included in individual closed claim reports into an aggregated summary format and shall

prepare a written annual report of the summary data. The report shall provide an analysis of closed claim information including (A) a minimum of five years of comparative data, when available, (B) trends in frequency and severity of claims, (C) itemization of damages, (D) timeliness of the claims process, and (E) any other descriptive or analytical information that would assist in interpreting the trends in closed claims.

(3) The annual report shall include a summary of rate filings for professional liability insurance for **[**medical professionals or**]** hospitals, **[**which**]** physicians, surgeons, advanced practice registered nurses and physician assistants that have been approved by the department for the prior calendar year, including an analysis of the trend of direct losses, incurred losses, earned premiums and investment income as compared to prior years. The report shall include base premiums charged by **[**insurers**]** insuring entities for each specialty and the number of providers insured by specialty for each **[**insurer**]** insuring entity.

(4) Not later than **[**March 15, 2007**]** May 15, 2011, and annually thereafter, the commissioner shall submit the annual report to the joint standing committee of the General Assembly having cognizance of matters relating to insurance, in accordance with section 11-4a. The commissioner shall also (A) make the report available to the public, (B) post the report on its Internet site, and (C) provide public access to the contents of the electronic database after the commissioner establishes that the names and other individually identifiable information about the claimant and **[**practitioner**]** provider have been removed.

[(e)**]** (5) The Insurance Commissioner shall provide the Commissioner of Public Health with electronic access to all information received pursuant to this section. The Commissioner of Public Health shall maintain the confidentiality of such information in the same manner and to the same extent as required for the Insurance Commissioner.

(f) Documents, materials or other information submitted pursuant to this section and in the possession or control of the Insurance Commissioner shall be confidential by law and privileged, and shall not be subject to subpoena or discovery or admissible in evidence in a private civil action.

(g) The commissioner may adopt regulations, in accordance with chapter 54, to implement the provisions of this section.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2010*	38a-395

Statement of Purpose:

To add clarifying definitions, to expand professional liability insurance closed claim reporting requirements, to grant the Insurance Commissioner the authority to fine entities that fail to submit reports as required and to add confidentiality provisions.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]